Learning Brief:

Safeguarding Adult Review - Jane

Jane's Story

Jane was a much-loved Daughter, Sister and Auntie. Her family were extremely important to her. She loved nature and the outdoors. She was a highly intelligent and independent woman who had previously worked as a PE teacher. In later life she experienced significant mental health difficulties, social isolation and increasing challenges managing daily living.

Jane was a woman with care and support needs linked to significant mental health difficulties, self-neglect, social isolation and vulnerability. Jane was found deceased, shortly after discharge from a mental health hospital ward and during a period when agencies were providing community support.

What Happened?

Jane was assessed by a Mental Health Practitioner after reporting severe depression, social isolation, and intensive suicidal thoughts. Jane disclosed that she was staying in bed for prolonged periods of time and wasn't going out, but she wanted company. She also reported that she had experienced a panic attack when she had recently tried to go to a bus stop. She stated she didn't like where she was living and wanted to move to help her feel less isolated. It was agreed with Jane that this information would be shared with Adult Social Care and that a referral for a package of care would be made. When Adult Social Care discussed Jane with the Mental Health Practitioner it was agreed that Jane would be referred again when her mental health had improved after she had agreed to be admitted to hospital.

Jane was later admitted informally to a mental health ward, where her care was reviewed weekly through multi-disciplinary team (MDT) meetings. Following a 12-week admission, she was discharged home with a care package from Adult Social Care and a referral was made to the Bury Home Treatment Team. This appointment took place within 72 hours of discharge from hospital; Jane denied any thoughts or plans for self-harm/suicide. Safety planning was discussed, support numbers provided and Jane was discharged back to the care of her GP.

Emergency services were called following a report that there was a serious incident at the property. North West Ambulance Staff (NWAS) spoke with Jane; she was encouraged to speak to the Pennine Care Foundation Trust (PCFT) Helpline about how she was feeling as she reported that she was struggling with her mental health. She didn't wish to be taken to the Emergency Department (ED) and was assessed as being low risk for self-harm and suicide by NWAS staff.

Jane was last seen by her Carer in early January. When subsequent visits were made for the next three days and there was no response, concerns were raised with Greater Manchester Police. Under the protocol Right Care Right Person, the carer was advised to make further enquiries to find out where Jane might be and were advised to contact the ambulance service. They were also advised that they could contact the Police again if required.

NWAS attended, with support from Greater Manchester Fire and Rescue Service (GMFRS) to gain access to Jane's property later that same day, but she was not at home. The Police were contacted again to advise that Jane could not be located, as a result a missing person investigation was opened. A meeting was held by the Police two days later, where appropriate discussions were held relating to how Jane might be. It was not until two days later that Jane was tragically found deceased in a field covered in snow, lying under an electric blanket with a bottle of alcohol approximately 2 miles from her home.

What we have learnt

Clear Lead Professional and Care Coordination

-No single agency or practitioner maintained oversight of Jane's escalating risks following discharge.

-There was a lack of clarity amongst professionals about who held responsibility for coordinating her care once mental health services stepped down.

Improved Multi-Agency Communication

Significant information was not consistently shared between agencies, including:

- Police contacts and welfare concerns.
- The serious incident at Jane's home.
- Changes to Jane's discharge arrangements.

Better information sharing may have enabled professionals to reassess risks and increase support sooner.

Earlier Use of Multi-Disciplinary Team (MDT) Meetings

-Several opportunities existed to convene an MDT after concerns about Jane's ability to cope at home emerged.

-Agencies worked alongside one another but did not consistently come together to review the overall risk picture.

Professional Curiosity Must Be Strengthened

-Some practitioners accepted Jane's explanations at face value despite reports suggesting significant self-neglect and deterioration.

-Professionals should explore discrepancies, challenge assumptions and seek a fuller understanding of a person's circumstances.

Person-Centred Care Planning

-The discharge support plan was largely task focused and did not adequately reflect Jane's social isolation, emotional wellbeing or expressed wishes.

-Future care plans should be developed collaboratively and address emotional, social and practical needs.

Mental Capacity Assessment and Recording

-There were occasions when Jane's presentation raised questions about her ability to make informed decisions.

-Capacity was often presumed rather than formally assessed and recorded.

-Agencies need assurance that capacity assessments are completed and documented whenever appropriate.

Hospital Discharge Planning

The support package arranged on discharge did not adequately address the risks associated with Jane's anxiety, isolation and previous suicidal thoughts.

-The review highlighted the importance of:

- Comprehensive discharge planning.
- Family involvement.
- Wellness and Recovery Action Plans (WRAPs).
- Early review and escalation where concerns emerge post-discharge.

What we have Learnt

Escalation of "Safe and Well" Concerns
-There was no clear protocol for commissioned care providers regarding prolonged periods of no contact.
-Expectations should be explicit about when concerns must be escalated to social care, health services or emergency services.

Referral Responsibility
-Some professionals appeared to assume another agency would make a referral.
-The review reinforces that duplicate referrals are preferable to no referral when safeguarding concerns exist.

Organisational Learning and Training
The review prompted several service improvements, including:

- Enhanced professional curiosity training.
- Stronger mental health leadership within the council.
- Improved commissioning requirements for care providers around missed visits and welfare concerns.
- Reinforcement of police referral and safeguarding procedures.

What do we need to do

To improve practice going forward, partner agencies need to strengthen joint working, communication and accountability when supporting adults with complex mental health needs. A clear lead professional should be identified whenever multiple services are involved, ensuring there is oversight of risks, care planning and coordination of support.

Agencies must improve information sharing, ensuring significant incidents, welfare concerns and changes in a person's circumstances are communicated promptly to relevant professionals. Opportunities to hold (MDT) meetings should be taken whenever risks increase or there are concerns that existing support is not meeting need.

Professionals should demonstrate greater professional curiosity, exploring discrepancies between what individuals report and what is observed by others, and considering the wider impact of isolation, self-neglect, financial difficulties and deteriorating mental health.

There should be a stronger focus on person-centred discharge planning, including family involvement, clear contingency plans and timely reviews following discharge. Agencies also need to ensure mental capacity is formally assessed and recorded where appropriate, rather than relying solely on assumptions of capacity.

Finally, clear escalation processes for missed visits, welfare concerns and safeguarding referrals should be established, with agencies encouraged to escalate concerns rather than assume another organisation will act.

Resources

4.10 Information Sharing and Confidentiality – Bury Safeguarding Adults Board APPP Resource

8.11 Professional Curiosity – Bury Safeguarding Adults Board APPP Resource

Access Professional Curiosity Training

Mental Capacity and Mental Health – Bury Safeguarding Adults Board APPP Resource

5.8 Multi Agency Escalation Process – Bury Safeguarding Adults Board APPP Resource